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Original Lectures.

HÆMATINURIA.

BY C. E. LANING, M. D., PROFESSOR OF DESCRIPTIVE AND PRACTICAL ANATOMY, AND CLINICAL PROFESSOR OF THE DISEASES OF CHILDREN, IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, OF CHICAGO.

This disease, while comparatively rare, is nevertheless considered to be more so than it is, from the fact that practitioners very frequently mistake it for hæmaturia. This may very readily be done, and if a careful analysis of a case be not made, including a microscopic examination of the urine, a positive diagnosis cannot be arrived at.

As an illustration of the above I will cite a case or two which have come under my observation:

Case 1.—Some months ago a gentleman came to my office to consult me in regard to hæmorrhages he was having. Upon asking him where the hæmorrhages were from, he replied he did not know nor could any of the doctors decide that point, but he had been referred to me with the hope that I might at least locate the lesion and discover the cause of the hæmorrhages.

I thereupon elicited the following history of the case. About a year and a half previous to the time of his consulting me he had drunk a little blackberry brandy with a friend, and on passing urine shortly after, noticed that it looked quite dark and red, but thinking it was only a temporary effect of the brandy he did not pay much attention to it. On evacuating the urine into a vessel he observed that it appeared to be highly colored with blood. He then consulted a physician who diagnosed the case as one of rupture of a small vessel in

the bladder, and gave the patient some medicine, assuring him he would soon be all right. And truly enough he seemed to be in a short time; the color disappeared from the urine, and he regained his normal condition in every respect. Very soon however, the hæmaturia, as it was considered to be, reappeared and this time remained persistently in spite of all treatment. At times it was checked by the use of quinine which the patient occasionally took for a feeling of general debility, accompanied by illy-defined sensations of chilliness. He observed that always, for a short time after taking the quinine, the urine became normal for a little time. No significance was attached to this fact, however, in the way of leading his physicians to a correct diagnosis. There was no history, nor evidence in the least, of a strain or blow which might have caused the hæmorrhage, nor was there evidence of any lesion of the urethra, bladder, ureters or kidneys, of such nature as to give rise to such profuse and persistent bleeding.

In my presence the gentleman passed about six ounces of urine, or rather what appeared to be so much blood, of a dark red color. He assured me that with few exceptions the evacuations from the bladder resembled in quantity and appearance that which he had just passed.

I was obliged to arrive at my diagnosis principally by exclusion. My first hint in the right direction was gained from his statement in regard to the effect of quinine upon the hæmorrhages. At once, thinking of its action upon the red corpuscles, I was convinced that the lesion, at least so far as the hæmorrhage was concerned, was in these minute cells. As all physicians know, or rather should know, a blood corpuscle has its birth, life and death just as all cells or aggregations of cells do. When the corpuscle is growing old, like an old man it becomes crenated, and the ruddy color of youth fades from it. Under some conditions, as with man, it looses its color and becomes wrinkled prematurely. If now a large number of corpuscles become so affected at a given time in an individual, what is the result? Let us trace out the changes which take place when the discs die a natural death, so to speak. As has been stated, they became shrunken and loose their coloring matter. What becomes of this pigmentary substance? It is taken from the old corpuscle as it passes through the liver, it is taken from the dying disc

as it rolls on through the current of blood, but after it is all out, the liver collects or strains it from the blood which passes through that gland and uses it as coloring matter for the bile, making the so-called bilirubine, which upon further oxydation becomes biliverdine.

Now we are prepared to understand what does, what must take place if the corpuscles die prematurely and in abnormally large quantities. An excess of coloring matter is thrown into the blood, more than the liver needs or can make use of. As the organs most nearly related in function to the liver, so far as excretion is concerned, come the kidneys. The liver, the kidneys, the skin, and lastly the mucous membranes, hold in the order named, a vicarious functional relationship, as it might be termed, to each other. The kidneys then, in such a case, as has been stated above, would naturally excrete, throw out of the blood the excess of hæmatine, and, as a consequence, there would be passed from the bladder a fluid resembling dark blood, or about the color of old port wine. What had the quinine to do with the case? Simply this, as I have already said, when a corpuscle is sick it shrivels and shrinks and looses a large per cent of its coloring matter, that is the condition of the greater proportion of discs in the disease under discussion, rather than one of absolute premature death. In such a state then, quinine, if given subcutaneously or per oram, very soon causes the diseased discs to resume their normal shape and color. Absolute experiment, conducted in a thoroughly scientific manner, has demonstrated this beyond doubt. The arrest of the "hæmorrhage" under the action of the quinine is readily explained. We need not necessarily go any farther into the case as regards the effect of the quinine upon the discs. It is sufficient to know that in this particular case at least its action was not permanent or curative.

Feeling positive that the corpuscles were involved in the manner already mentioned, the next step was to see what caused them to be so affected. As I have always claimed, and sincerely believe, that all disease originates in or implicates the nervous system more or less extensively, so in this case, it must have been at fault. Of course we know there is not,

nor would it be possible, for any direct connection to exist between the discs and nerve centres. How then are they influenced through these centres? Certian blood glands as the spleen, liver and thyroid, have a decided effect upon the chemistry of the blood, particularly upon the discs. The nerve centres then, which control these organs are the ones which exert an influence upon the corpuscles. So far as we know, all the functional activity of a gland is transmitted to it through fibres of the sympathetic system. Therefore, in the centres of origin of the sympathetic nerves distributed to the spleen and liver, the real lesion which gives rise to hæmatinuria, should be found.

The iron and the coloring matter of the corpuscles sustain an intimate relationship to each other, so that if one is lacking the other is more or less so. Thus if the disc is deficient in iron, it is not capable of absorbing, so to speak, or of retaining a normal amount of hæmatine. These substances being diminished beyond a certain proportion in the discs, lowers their power of carrying oxygen, hence, the weakness of the nervous system in general, the health of which depends so largely upon this function of the blood cells.

We can now see why the patient, a naturally hearty man, felt occasionally the depression and languor and chilliness of which he complained, and for which he took quinine with decided though temporary benefit. Such a patient must of necessity be unable to sustain any prolonged or severe exertion such as might formerly have been undertaken with impunity. He will "get out of breath" more easily than usual, for the increased demand for oxygen, which is always set up when tissue changes are taking place, *i. e.* as the result of physical exertion, could not be supplied on account of the diminished oxygen-carrying powers of the discs.

I may here state what I neglected to earlier, that a microscopic examination of the urine confirmed my diagnosis, there being but few corpuscles present, none in some of the fields and most of those seen were old broken down ones.

Having followed the case out so far, what shall we do to

cure the patient? He has had old school and homœopathic treatment without avail. The only relief has been from quinine, which, as has been seen, was merely transient. The human body is a piece of mechanism, very delicate, very wonderful, it is true, but nevertheless subject to the same general laws, as other mechanisms, plus vital action. If in a watch one wheel, one pinion, or spring be out of order for any length of time, other parts of the mechanism become deranged, so that even if the first lesion be removed others which have been developed as a result of it will still keep the machine from working harmoniously. Therefore, when we commence to rebuild, to repair, let us put all the parts in a normal condition at the same time if possible.

Pardon this digression, but it is made for the purpose of making the treatment and its results more clear. Besides the oxygenic function of the blood cells, they also contain the glycerized phosphates. In short the nervous system gets its nourishment almost exclusively from the discs and not from the plasma; just as an unbalancing of the proper proportion of iron affects the ability of the corpuscle to retain its due amount of hæmatine, so also do derangements of this kind affect its power, to absorb and distribute to the nerve centres the form of phosphates just mentioned. Having this condition present in our case, as shown by the symptoms; having a functional derangement of the liver and spleen back of it, and having still back of all, a functional derangement of the nerve centres controlling these organs, I gave as a remedy, ferrum phosphate, known to act upon said centres, causing on the one hand the condition present, in a greater or less degree, or on the other hand removing it. It was given in the third trituration, two grains three or four times a day. In four days the hæmatinuria had ceased, after virtually having been present for one year and a half, and up to this time, several months after the date of the prescription, there has been no return of the symptom whatever.

Case 2.—Since the above case presented itself for diagnosis and treatment, another one of the same nature, though not quite so marked, has come under my care. A gentleman,

aged forty-five years, came to me complaining that he had been troubled for the past six months with occasional hæmorrhages from the bladder, which the physicians who had treated him had not been able to control. The case began with a history of dengue or swamp-fever contracted in the South some years ago. This fever had apparently been cured in a short time by large doses of quinine, but nevertheless had shown itself in a more or less decided manner at irregular periods since, the patient's former perfect health having at no time been entirely restored. During these periodical returns the patient felt languid and listless, with a sensation of heat all over the body and slight aching of the lower limbs, the tongue was coated yellowish, the mouth tasted bitter, the appetite was almost *nil* and the bowels constipated, the stools being dark, foul-smelling, and of a soft, doughy consistence. The urine at such times was usually high-colored and contained an excess of mucus and urates. With slight variations such attacks had repeated themselves at intervals of a few months, until during one about six months ago, the patient observed that the urine he had passed during the night—not having observed it at the time—was apparently but so much blood, in the morning. He at once consulted a physician who diagnosed it as hæmaturia, and after treating him for a couple of days it, and all the other symptoms incident to the attack disappeared.

Within a week the hæmorrhage returned, to leave again in a few days. In short, a recurrence of the hæmorrhage from two to three times a month, caused the gentlemen to consult several physicians in regard to it, all of whom agreed upon the diagnosis, hæmaturia, and although their treatment varied, the result was the same, an irregular return of the difficulty.

In this patient the disease manifested itself in what might be termed the usual manner, that is, it was paroxysmal. Evidently, as is often the case, malaria was the prime etiological factor. The entire picture of the case, with the exception of the hæmaturia, was clearly indicative of portal congestion of a decided character. The dark tarry stools pointed to exudation of blood through the capillaries which go to form indirectly the portal vein through the superior and inferior mesenterics. The coating of the tongue was a direct outgrowth of this stasis, brought about in a manner I will explain at another time.

Functional derangement of the liver was self-evident, and such a condition of that organ as has been just outlined cannot possibly exist without implicating both the stomach and

spleen, since the veins from both these organs unite to assist in the formation of the portal. The liver and spleen both being in an abnormal condition, it will be readily understood how the discs may be affected, not necessarily because these organs are deranged, but for the reason that they are implicated in a certain manner. The liver, it must be remembered, is literally a double gland, being both a biliary and a blood gland; this is true from both an anatomical and physiological point and from a purely physiological side, it might be divided into as many glands as it has functions, since there can be little doubt that certain cells are detailed to the performance of special functions. Histology, physiology and pathology, all give strong evidence in this direction.

In the first case cited we gave the ferrum-phosphate, for reasons already stated. In that case there was no evidence of derangement of other than the cells of the liver and spleen, whose function it is to elaborate the discs. The only positive evidence of this was the presence in the urine of hæmatine. This was, of course, accompanied or rather preceded by hæmoglobinæmia, but the fact that that condition was present and the consequent affection of the liver and spleen, was only made manifest by the hæmatinuria, since the lesion which caused this seemed to be the primary and only one, a prescription based upon these facts was given.

In the latter case, however, there is every reason to believe that the lesion giving rise to the hæmatinuria was secondary in character, and therefore a prescription must be made with this fact in mind.

All of the symptoms in this case, except the hæmatinuria, point to a condition of the various tissues involved, such as leptandria causes and cures. Accordingly that was given, two cones medicated with the third, four times a day.

If after all the strictly leptandria symptoms have disappeared, we find that the reflex or secondary lesion has become so firmly impressed upon the system as to still remain after the initial lesion has been removed, other treatment will be necessary. If another remedy should be required, unless there are special indications for something else, I shall prescribe ferrum-phosphate in the same manner as in the first case.

This patient I have seen only once, so cannot as yet state what the effect of the medicine has been or will be.

In this case, there was a complete absence of discs, and a large amount of albumin in the urine. Just such cases often terminate in Bright's disease.

As was said in remarking on the last case, hæmatinuria is generally spasmodic in its character, coming perhaps suddenly, and lasting a few days, to as suddenly disappear. In such instances it may be that the splenic or hepatic difficulty, upon which it is dependent, are transitory and hence the irregular, uncertain periods of attack. Or may it not be possible that even though the derangement of these blood glands is permanent, that only at certain intervals there is accumulated in the blood sufficient hæmatine to require the assistance of the kidneys in removing it. After the quantity has been reduced below a certain amount, the system tolerates it, that is, its presence up to a certain limit, does not in a reflex way stimulate the kidneys in such a manner as to cause them to excrete it.

However this may be, it is rare that a case is so continuous and persistent as the first one cited. The causes of this peculiar symptom are numerous. Malaria as has already been mentioned is a frequent one, as is also sudden chilling of the skin from exposure to cold air or from getting wet.

Mention was also made of the belief that a nervous lesion was the primary cause of this affection, upon this as well as some other points in regard to the disease, I will quote Aitken, who says:

"There are also certain premonitory peculiarities in the recorded cases of this disease which point to a nervous rather than a nephritic origin, as a severe neuralgia, sometimes of the trunk and sometimes of the extremities; also severe formication quickly followed by lassitude and cold shivering, the occurrence of urticaria developed by the application of cold water, but not produced by tracing lines upon the skin, or by any other form of mechanical irritation. It has also been associated with the rheumatic constitution. It has also been attributed to injury over the renal region, and to the influence of malaria, and in connection with septic fevers, purpura, and scurvy." Of the symptoms, the same author says:

"It comes on in sudden and irregular paroxysms occurring during the day, and lasting from three to twelve hours. Certain premonitory phenomena already mentioned

usher in the attack, also chills, a sense of weight in the bowels, dull pain or tenderness over the region of the kidneys. The temperature may fall below the normal. The urine passed is of a dark or red color, resembling porter or port wine; the intensity of coloring varying with the intensity of the cold producing the attack. It is turbid and throws down an abundant sediment and is highly albuminous. It rapidly recovers (twelve to twenty four hours) its normal condition. In the intervals it is quite normal. Spectroscopic examination shows that hæmaglobin is present, while Drs. Forrest and Finlayson's examinations indicate the presence of the separate ingredients, as determined by spectrum analyis."

Careful experiments, which have been conducted by a number of competent observers, demonstrate beyond doubt that the hæmatine is separate from the discs before they reach the kidneys, and accordingly they only excrete it, it in no sense being a secretion. Extensive burns upon the surface as has been proven conclusively by Van Lesser, almost invariably produce hæmaglobinæmia, with its resultant, hæmaglobinuria. The dyspnœa so often arising in the course of severe surface burns, he very reasonably ascribes to the loss of coloring matter which the discs sustain. It will be remembered what has already been said about the relation of the hæmatine and iron, hence, it will be readily understood that the blood cells power of carrying oxygen is diminished. Is it not possible that the symptoms of nervous depression, often amounting almost to syncope may be due largely to the same reason, viz.: the functional destruction of a large number of red corpuscles, which furnish almost exclusively the nutriment for the nervous system.

The discs may be affected in such a manner as to give rise to hæmaglobinuria, by a number of substances. Thus, as Ponfick first pointed out, this condition may be produced by eating a certain fungus called morchella esculenta. Litten found that by using anilin and dimenthylanilin hypodermically, he was enabled to separate the coloring matter from the blood cells in living animals. Glycerine if used too freely may cause the same result. Pyrogallic acid and naphthol when introduced into the system by means of inunction have caused hæmatinuria, likewise potassium chlorate when intro-

duced through the stomach. Dr. Neisser reports a case in which the red corpuscles of a man underwent fatal dissolution after the inunction of pyrogallic acid.

Dr. Eitner, quoted by Frederick P. Henry, in his article on hæmoglobinuria in the "Reference Hand-Book of the Medical Sciences," reports a case in which a professor of physics and three assistants suffered from an attack of this affection, after inhaling hydrogen gas, which was afterward found to contain a certain per cent of arsenic. He also mentions several other cases in which death resulted from a similar cause. Dr. A. Jacobi has collected the history of twenty-seven cases of poisoning by chlorate of potassium, in the majority of whom hæmaglobinuria made its appearence and was followed by fatal results in twenty-three out of the twenty-seven.

Dr. Dreschfeld and Mr. Stokes, of Manchester, England, are quoted by Frederick P. Henry, in their report of a case of a woman who had taken an ounce and a half of potassium chlorate, in the course of twenty-four hours for a sore throat, and who "was suddenly seized with cyanosis and dyspnœa, and who passed masses of hæmaglobin both per rectum and per vaginam, the urine and the vomited matter also contained masses of hæmaglobin."

According to good authority the first recorded case of hæmatinuria was written by Charles Stewart, in Duncan's "Medical Commentaries for 1794." Harley, in 1865, seems to have been the first to establish thoroughly the nature of the disease, and to have discovered and stated that the urine was impregnated with the coloring matter of the blood. The resemblance between haemaglobinuria and Raynaud's disease is so close in some instances as to be practically indistinguishable. Particularly is this so when in the former disease there is present a high degree of local ischaemia, such as sometimes occurs. Henry quotes Dr. Fagge as mentioning "several instances in which the ears not only turned livid during the seizures, but failed to regain their natural appearance afterward, so that a reddish brown eschar formed along the edge of the helix, leading to a permanent loss of its sub-

stance." Dr. Fagge's opinion is that such cases belong to the catagory of Raynaud's disease.

After a severe paroxysm, jaundice is not infrequently developed, furnishing, as Henry remarks, "complete evidence of the hæmatogenous form of icterus." Sometimes the icteroid symptoms are not so apparent, there being present only a slight sallowness of the skin. It is remarkable how rapidly a patient may recover from an attack, sometimes within two or three hours from the time of the onset the patient will have few or any symptoms remaining.

Some persons have a peculiar susceptibility to this affection. Thus, Ehrlich found a man in whom a local hæmaglobinæmia could be produced at will, simply by placing a ligature around one of his fingers, and then immersing it in cold water, blood drawn from below the point of ligation showed that the characteristic changes incident to the above disease had taken place. Dr. Carl Heinemann of Vera Cruz, according to Henry, "withdrew blood from a patient by means of a cupping glass, from the thorax, and examined it under the microscope. All the corpuscles were found deprived of their coloring matter, and swam as pale colorless discs in a deeply colored plasma. They were all diminished in size, their rounded border having apparently been partially melted away."

In considering the pathological side of the disease it must be remembered that there are always at least two important points to bear in mind, viz.: Whether the hæmatinuria is due to the freeing of the hæmaglobin as a result of actual death, and breaking up into fragments of the corpuscles; or whether on account of functional derangement of the discs, causing them to lose a large percentage of their coloring matter, but nevertheless remaining in such a condition, that under appropriate treatment they may once more become capable of retaining their hæmaglobin.

In the first case, which is the condition which results from severe burns, the spleen is the organ principally implicated. It becomes swollen to such an extent on account of the extra work put upon it, that it may often be detected in the shape

of a tumor in the left hypochondrium. May there not be some connection between the well-known efficacy of arsenicum, in this class of burns, and its demonstrated action upon the spleen.

In the second class of cases, the liver is principally involved. As stated before, nominally, this organ removes and converts the coloring matter of broken down corpuscles into bile pigment. According to Ponfick, the liver becomes unable to remove the excess of hæmaglobin after it exceeds one-sixtieth of the total amount in the blood. When the quantity in the plasma is in excess of this, then the kidneys must be depended upon for its elimination.

We might sum up in brief by saying that the one necessary condition which must be present, in order that hæmatinuria may exist, is that the red corpuscles are for some reason so affected that they give up their coloring matter more easily than is normal. Except in the case of the introduction directly into the blood of some foreign substances which may act directly and deleteriously upon the corpuscles, it is most probable, as was remarked some time ago, that the lesion is in some of the blood glands, or primarily in the nerve centres controlling them.

As to the treatment, I can give but little outside of what I have learned by personal observation and a theoretical study of the disease. I have not been able to find a single case mentioned in homœopathic literature. The old school make use almost exclusively of iron and quinine, singly, or in combination, and report cures of most of their cases. The fact is, the disease, with such rare exceptions, being paroxysmal, intermittent in character, and withal liable to disappear without other than general treatment, *i. e.*, what the old school term "sustaining," it is no easy thing to be sure one has absolutely produced a cure by means of any drugs he may have administered. The first case mentioned being such a exceptional one, as to continuous duration, gives us at least the right to a strong inference that the remedy prescribed exerted a curative influence.

A careful study of the etiological factors in a given case will often throw much light upon the treatment. Exposure to cold is one of the most frequent causes, next to this, perhaps, comes malaria and syphillis. Toxic substances likely to produce this difficulty have been mentioned already.

The principal remedies would seem to be arsenicum, ferrum, phosphorus, china, secale, croccus (?), nit. acid, potassium iodide, and mercurius; the last three named being indicated, of course, where there are evidences of a specific taint.

Clinical Society Transactions.

DR. A. K. CRAWFORD, SECRETARY.

JUNE MEETING, 1887.

The regular monthly meeting of this Society was held in Club Room 4, of the Grand Pacific Hotel, on Saturday evening June 4. Dr. G. A. Hall was called to the chair, and in the absence of Dr. Crawford, Dr. E. S. Bailey acted as secretary *pro tempore*. The first thing on the programme was

THE ADDRESS OF THE PRESIDENT.

BY GEORGE F. SHEARS, M. D.

MEMBERS OF THE CLINICAL SOCIETY:

In assuming the office of president of this Society I desire to express my profound appreciation of the honor you have conferred upon me. I was both surprised and pleased to learn of your action; surprised, because circumstances prevented me from attending the annual meeting of the Society, and I was therefore entirely unaware of your instructions until I saw the notice of my election in the morning papers; pleased, because you deemed me worthy to act as your presiding officer, and to a certain extent to represent this distinguished body. In making use of this word, distinguished, I speak not the ordinary words of courtesy, but, as I believe, the words of truth. When we compare the work done by this Society with the work of other and more pretentious organizations we may be greatly pleased with our results.

It was only the other day that while investigating a subject of some interest to me I looked over the transactions of this Society since 1880. The work recorded in these eight volumes of the CLINIQUE would be a credit to any society or

organization. How little bombast, how little theory, how few useless discussions are therein contained. On the other hand how much work and care the papers show, how painstaking and honest the report of cases, how free, yet courteous the discussion. And yet, while pleased with our Society, I am not wholly satisfied, I am glad to say, for to be satisfied is to cease effort, and to cease effort is to retrograde. While then, I desire to congratulate the Society upon its year's work, I desire to urge it to do better work in the coming year. I can hardly urge the bureaus to be more punctual with reports, for the unfailing promptness with which the bureaus have reported is almost phenomenal when we consider the arduous duties of the profession, and the many obstacles in the way of regular and continuous literary labor. But there is one direction in which it seems to me there is room for improvement, and that is in the attendance of the different members. We should make an effort to attend, if we desire to make this Society a typical medical society, not only the report of the bureau to which we are attached, but the reports of all the bureaus. All divisions in medicine are arbitrary; no natural divisions exist. The neurologist, the dermatologist, the oculist, the electrician can not limit his knowledge to the specialty that he practices. All branches of medical science are indissolubly united. The gynecologist can enlighten the path of the dermatologist; the aurist, that of the general practitioner; the surgeon, that of the neurologist, and *vice versa*. A report viewed from all these sides, and discussed by all these specialists and physicians, is as much more valuable to the physician than a single report as the testimony of both plaintiff and defendant are to the jury than the statement of only one of the interested parties. The discussions are often the most valuable part of the report. Here is obtaining individual experience, not gathered statistics. Here the salient points of a topic are placed in juxtaposition as they occur in practice, not in different divisions as they must be placed in a more systematic treatise. Here the statements of the enthusiast are modified by the experience of the conservators, and the doubts of the pessimist by the positiveness of the optimist. These

discussions cannot be reported, the look, the emphasis cannot be reproduced, and in most instances only the substance of the remarks are saved for publication. If then we desire to make the most of our opportunities and of our Society let us attend its meetings regularly. Let us come prepared to talk intelligently, and add to the scholarly effect of the written paper the life and emphasis of the spoken word.

THE DIFFERENTIAL DIAGNOSIS OF THE ERUPTIVE FEVERS.

BY DR. T. S. HOYNE, CHAIRMAN.

At the request of a member of this society I have selected for the subject of my report the differential diagnosis of the eruptive fevers. When the symptoms in a given disease, as measles for instance, follow the general order as regards the premonitory symptoms, the time of eruption, the location of the same at first, the accompanying phenomena, etc., there is but slight difficulty in making an early diagnosis; but when, as happens in a certain proportion of cases, the symptoms are mild or irregular, following none of the general rules, the wisest heads are often puzzled for a time, at least, before being able to pronounce a positive diagnosis. I suppose that it is on account of the difficulty experienced in these unusual cases that the member of the bureau requested a discussion of this subject to-night. The health officers of this and other cities are frequently obliged to reverse the decision of physicians who have too hastily reported cases of small-pox and scarlatina, which proved to be, on a more careful examination, measles, rotheln or roseola.

Let it be remembered that the day of the eruption has much to do with the diagnosis. In rotheln, roseola and varicella, the rash appears on the first day; in scarlatina on the second; in variola on the third, and in measles on the fourth. In rotheln, roseola and varicella no symptoms of significance precede the eruption. In scarlatina the vomiting and high grade of fever are characteristic. In variola, the decided

chill, the lumbar pain and frontal headache are pathognomonic, as are the catarrhal symptoms in rubeola. The eruption at first is papular in variola and rubeola; vesicular in varicella, and patchy in scarlet fever, roseola and rotheln.

By far the most common error in diagnosis is the mistaking rotheln for measles, or *vice versa* especially during an epidemic. If the case is a typical one there is no excuse for the blunder, but when the eruption in rubeola appears before the fourth day, with slight constitutional disturbance, the mistake is certainly pardonable. In rotheln the eruption appears on the first day, only occasionally on the second, with sometimes slight catarrhal symptoms, and it then resembles very much that of rubeola. The spots, however, are bright red, not dull red, raised, rounded, soon coalescing, but not crescentic in form. The temperature may rise gradually to 103° or 104°, and subside on the third day. In measles, on the other hand, there is a gradual rise of the temperature before the appear ance of the papules, and a gradual dropping of the same afterward. Coryza with sneezing does not precede the rash in rotheln, but may follow it. Cough is rarely a prominent symptom in the latter affection.

Rotheln and scarlatina are sometimes confounded when the cases of the latter are unusually mild, with slight eruption and no throat symptoms to speak of, and it is not to be wondered at when it is remembered that the temperature in he former may be as high as 104°, and in the latter may not exceed 102° or 103°. The pulse may be greatly accelerated in both. The eruption in the two affections is often quite similar, especially on the second day of rotheln, when the spots may have run together, producing a uniformly red skin. Upon looking into the throat, however, the distinguishing symptoms of scarlet fever are absent, although there is a slight redness of the fauces and uvula. In a certain proportion of cases the diagnosis must be based on their occurrence during an epidemic, or if the case can not be traced in this way, one must wait for the appearance of complications or sequelæ. Renal disease is the most frequent sequel of scarlatina, while in rotheln, as a rule, there are no complications

and no sequalæ. A sudden attack of vomiting usually ushers in a mild as well as a severe attack of scarlatina, and when this is followed by considerable fever, with redness of the fauces, during the prevalence of this disease, there is slight danger of making an error.

Measles and small-pox are occasionally mistaken the one for the other. The hard shot-like feel of the papule in the latter affection, and the softness of the eruption in the other mark the difference. The quick transition of the papule into a vesicle leaves no room for doubt. The decided chill in variola with the frontal headache and backache, and the decline or complete absence of febrile phenomena after the appearance of the rash are pathognomonic, and remove all grounds for uncertainty. In rubeola, when the air passages alone are affected, a positive diagnosis is not possible, but such a case could not be mistaken for variola. Such cases are extremely rare. On the other hand when the eruption is slight in rubeola and the air passages unaffected, it is apt to be mistaken for rotheln or roseola.

Varicella creates considerable interest at times. Let it be the first case in a neighborhood in the fall or winter, or the young doctor's first experience with it, and there will be much perusing of standard authorities. But it is not only the young men who mistake the one disease for the other. The old war horses are sometimes puzzled. Some years ago, while connected with the city health department, I was, on a winter's night, sent away out Archer Avenue to examine a case which had been pronounced small-pox by an old school gentleman of very large experience. To my surprise the child had varicella and nothing else. There had been no symptoms whatever until that day, when the eruption appeared as large vesicles, some ten or twelve in number. The parents, you may believe, were greatly relieved. The fact of the matter was, the aforesaid physician did not take time enough to properly examine his patient.

The main distinction between these diseases is, of course, the fact that variola and varioloid commence with a papular eruption whilst varicella invariably begins with a vesicular one.

In variola the eruption appèars after a few days' illness on the face and wrists, while in varicella it is apt to appear first on the body without previous illness. It is always more abundant on the body in chicken-pox. It is hardly possible to mistake the one affection for the other, if any examination whatever is made.

Roseola has been mistaken for variola, varioloid, rubeola, rotheln and scarlet fever. Such errors cannot possibly occur except when the latter diseases are exceptionally mild in character, and even then a day or two of time ought to clear up the diagnosis. Roseola is an affection of no importance *per se*, but during the prevalence of the more serious fevers it is of the utmost importance to make a positive diagnosis. The patches in roseola are scattered, circular in form but not elevated, of a rosy color accompanied by itching and a sensation of heat. There is usually some fever, but no catarrhal symptoms, no soreness of the throat, no vomiting, no backache nor headache. The patches may be confined to a part of the body or widely diffused; they come and go for a number of days. The disease is more often seen in the summer season. There are no complications or sequels.

Hoping that I have in this brief report fulfilled the wishes of the member of the bureau, I now give way to those who wish to discuss the paper.

Discussion.—Dr. W. M. W. Davison remarked upon the great value of such a paper, as it was in difficult cases where the doctor was really the referee; and as simple as it may seem, not even the health officers of great cities are always free from errors of diagnosis. As proof he cited the fact that he had fought to have a case of measles retained at the patient's home, while the health inspector of the same district insisted that the case was one of small-pox. It would not seem necessary to call attention to such a condition of affairs if the points of diagnosis were always clear and positive. The patient remained at home and had the measles.

Dr. H. P. Skiles—It has been my fortune to pass through an epidemic of measles, several of them for that

matter, and in this particular one every case in a few particulars was similar to the prominent symptoms of small-pox. There were a few points in differential diagnosis that had not failed, and recently when called to decide between a case of measles or scarlet fever, in the person of a little child two years of age, I decided that it had the measles because of the peculiar odor emitted from the patient. The majority of the symptoms, such as the high temperature, the scarlet hue of the skin, the suppressed urine, the sore throat, the strawberry tongue, would have suggested scarlatina, but while measles may have these symptoms, scarlet fever does not have the odor of measles. He was taught to believe that a child under six months of age would not have the measles. Had any one proof to the contrary?

Dr. H. P. Holmes—I would like to ask Dr. Skiles if, in these cases where he finds the glandular complications, there might not be a psoric diathesis at the bottom of the trouble. I have seen several cases where the cervical glands were somewhat enlarged, and was quite positive that scrofula was a hereditary taint and considered that the cause.

Dr. N. C. Kemp—The question was recently asked me, can the same patient have measles more than once, or more than twice, and where is the limit of susceptibility?

Dr. T. S. Hoyne.—One attack of measles usually exempts from the second attack. Rotheln as a rule exempts from a second attack, but it does not exempt from the measles.

Dr. H. P. Holmes—I would like to ask Dr. Hoyne a question. Do you consider roseola and rotheln one and the same thing?

Dr. Hoyne—Certainly not, they are two separate and distinct diseases.

Dr. Holmes—I have been very much interested in the paper and the discussion, especially on roseola and rotheln, as we have been having quite an epidemic of what is popularly termed "German measles." I have examined and treated some thirty cases and have noticed two forms of the disease, and have wondered if it was simply variations of the

disease known as rotheln, or German measles, or if two diseases were really present.

The great majority of the cases are mild ones, the patients not being confined to their beds, and many of them attending school through the whole attack. The cases range in age from five years up to adults. I have neither seen nor heard of babes having it. The first symptom apparently noticed by the patient or friends is the rash appearing on the neck and spreading upward and downward. It is thickest on the face, neck and body, being rather scattered on the extremities. The rash as a rule is composed of circular red spots, which become brownish-red with a darker centre, and the general feeling is rough or scratchy. The spots as a rule are separate, although where thickest they coalesce and form large blotches, especially in parts exposed to the greatest heat of the body, as under the arms, in the groins, flextures of the elbows and knees, the parts lain upon, etc.

In the other form of the disease there is a universal redness of the skin as in scarlatina, and the rash appears as smooth, rounded lumps under the skin, much like the elevation in urticaria.

In all cases there has been conjunctivitis which remains until after the patient is up and about. There is a fine rash appearing on the velum palati, and I have recognized this three days in advance of the rash. The fauces are highly inflamed although the patient invariably denies having a sore throat. There is great restlessness in those confined to bed, and I find it a key-note for *Rhus tox.* which has done splendid work for me. In a case which I saw this morning there had been vomiting and diarrhœa, both of blackish water with black shreddy particles, as if from internal hæmorrhage. There was great thirst for cold water which was vomited immediately on drinking. The character of the thirst, vomiting and diarrhœa led me to prescribe Arsenicum which rapidly modified the attack. As a rule there is no cough or catarrhal trouble, and thus far the disease does not seem to be contagious as in several instances but one child or person in a family has been attacked.

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Dr. Hoyne—I think the diagnosis is not clear, but that the better decision would be to call the former rothlen and the latter roseola.

Dr. J. E. Morrison, of Urbana Ill.—I have been particularly pleased with the paper and the discussion thus far, and am at the present time interested in gaining all the information possible on this subject. I have just been through an epidemic of measles and have had sixty cases to treat. Among other things that I have noted in particular was that fully two-thirds of these cases were ushered in by a chill. Sore-throat in all these cases was very common. For the first time in my experience I tried to get some statistics relative to the possibility of a recurrence of a well-marked case of measles, and I am assured that twenty-one out of the sixty cases had previously had measles. One lady fifty-one years old assured me that she had had two other attacks of measles, similar in every way to the one from which she was suffering, and which I was at that time attending.

In an epidemic that went through the town where I was formerly located, I fully believe that a large per cent (*Secretary*, how large?), say twenty per cent, had had the measles in varying degrees before the outbreak of this epidemic. My individual experience in this kind of epidemics is that I can not attend a case of measles without having all the catarrhal symptoms of the disease; my eyes get weak and watery, and for several days the cough is very marked, leaving always a sensitiveness of the throat. I have had the measles several times, once in my youth, and several times very marked symptoms of the same affection.

Dr. R. Ludlam appreciated the merits of Dr. Hoyne's paper and had enjoyed the discussion. One important lesson taught by clinical experience is that diseases of a similar kind often merge and are not so distinctly presented at the bedside as they are in the books. The eruptive fevers, and eruptive diseases generally, are very prone to be of a mixed type. The essayist did wisely in directing our attention to this class of cases, for they are sometimes very confusing and troublesome. Some years ago he had unfortunately mistaken a very bad case

of measles in an adult, whom he visited but once, for small-pox. He reported it as suspicious to the health department. An expert was sent to examine the poor fellow, and he too thought the man had what would develop into confluent variola. The case was taken from the boarding house, where he was an unwelcome visitor, to the pest-house, where he went through with a bad attack of measles. The result was that some kind friend fired a gun at me through the window of a newspaper on account of my ignorance in the diagnosis of two very common diseases.

In subsequent experience he had learned to depend in doubtful cases upon the recognition of measles especially by the early appearance of the eruption in the throat, and upon the peculiar odor of the disease. In scarlet fever he had also felt that, if we look for them, we shall find that the renal symptoms are almost as certain to be present in the early stage of the attack as are the catarrhal symptoms in the case of measles.

Concerning the tradition that one attack of either of the eruptive fevers gives exemption from a repetition of the same, he certainly thought the rule would hold good with very few undoubted exceptions. Nothing is more common than to hear of children, and even adults, having had the measles or the scarlatina two or more times; but he could not help feeling that if the real facts were known there must have been a faulty diagnosis in former attacks. It is very easy for one who is not a physician, and for doctors too, to mistake a case of rotheln for one of measles, and to insist that the patient who has had the former should escape the latter. And, besides, it is such a little while since we knew anything about rotheln that our friend Dr. Morrison might find his figures changed if he had known all the facts when he saw so many recurrent cases in Paxton twenty years ago.

Dr. E. S. Bailey—Before this discussion ends I would like some help in the diagnosis of a sequel of rotheln and will state my case: Two little girls, the one seven and the other five years of age, came down with a strictly marked rotheln; they were very ill for three days but convalesced very rapidly.

When all seemed to be doing well the elder one was suddenly taken with a chill, lasting an hour. At 11 A. M. the fever following was high, 103⅖°, and lasted until 4 A. M. The chill was repeated the next day at the same time, and the fever was the same although much milder in degree. The third day the chill came at 8 A. M. lasting an hour; the fever was not so high, 100°. On the fourth day the mother noticed a swelling of the parotid glands and the child complained of pain back of the ears. The impression was that the little patient had the mumps. There was no history of any direct exposure, save a week prior to coming down with the measles—a period three weeks removed or more. The symptoms of the mumps were not clearly defined. The younger child is following exactly through the same ordeal, though twenty-four hours behind her elder sister.

Dr. Hoyne—Usually rotheln has no sequelæ. Sometimes, and I have seen it in one of my cases recently, the cough is like a whooping cough, and one day it would seem that remedies for the cough were necessary, the next day the febrile or eruptive symptoms would call for treatment. This alternation is sometimes quite pronounced.

[Mrs. Dr. B. L. Reynolds reports that of fifteen cases of rotheln which occured in the Home for the Friendless in this city during the month of April, 1886, four were accompanied by an enlargement of the *sub-lingual* glands. Not one of them had the post-auricular swelling which some authors regard as pathognomonic. In the most severe cases there was some desquamation. In the majority of those, and of subsequent cases treated in the same institution the eruption disappeared in from thirty-six to forty-eight hours. The measles were not prevalent in the Home at that time, but the mumps were.]

Electrolysis in the removal of hair, nævi, etc.—By H. P. Holmes, M. D., Sycamore, Ill.—In July, 1885, I made my first experiments in the use of electricity in removing superfluous growths of hair, moles, nævi, etc. The battery used was a McIntosh eighteen-cell galvanic. From seven to twelve cells were used, according to the strength and

condition of the battery-fluid and the condition of the parts to be operated upon. The best electrolytic needle I have found I made by taking a barbed, flexible nerve-broach, such as is used by dentists, and grinding it down longitudinally on a dentist's grindstone until finer in calibre than the hair to be operated upon. This needle is then attached to the negative cord, and is protected by a piece of rubber tubing, covering the attachments and needle down to within one-half an inch of the point. The advantages of using such a needle are its flexibility, durability, cheapness and, if broken, it may be ground down still farther, thus taking the place of at least three ready-made needles, and should it be too coarse at any time it may be finished to the proper size.

Case 1.—The first patient operated upon was a young lady with a mustache so well developed that had its possessor been a young man of twenty, he would have doted upon it. Coarse hairs had sprung into quite a vigorous growth which was apparently cultivated by frequent and careful shaving.

The patient was seated in a reclining chair in a good light. Eight cells were used in the work. The needle was carefully inserted into the hair follicle, and when it had reached the bottom, a depth of perhaps one-eighth of an inch, the circuit was completed by the patient grasping the sponge electrode attached to the positive pole. A peculiar crackling sound was heard along the needle, and at the end of a few seconds a dry, white, frothy substance appeared at the point of operation. The patient now dropped the sponge electrode, the needle was withdrawn, and the hair was easily removed with a pair of forceps. This was repeated, choosing hairs widely separated to avoid making the face sore, until in four sittings the troublesome growth was removed.

Too strong a current, improper introduction of the needle so as to pierce the follicular wall, or attempt to introduce the needle with the circuit closed blistered the tissues and made the face sore. The result of the operation was entirely satisfactory, as at the end of a year the growth had not returned.

Case 2.—A young lady with a hairy nævus, one of the

nævi pilosi pigmentosi, on the right cheek the size of a silver dollar. In a few sittings over two hundred hairs were removed when the patient failed to materialize. Meeting her some weeks afterward and asking her the cause of her non-return, she told me she had given up having the "mole" removed as her friends told her if it was taken off her face it would go to her liver. No argument on my part could convince her of the folly of such a statement, and she still wears the ornament though it is not so hirsute as before.

Cases 3, 4, 5 *and* 6.—These were for the treatment of moles, two of them on the face, and producing a few long, coarse hairs, one on the neck and one on the hip. The latter was given to suppuration caused by irritation from the clothing. The hairs were removed in the manner before stated, and then the needle was thrust through the tumor at its base, the circuit closed, and the needle allowed to remain until it could be moved freely in the growth. The circuit was then broken and the needle reintroduced at right angles to the first puncture, and the tumor treated as before. There was not the slightest hæmorrhage and the results were satisfactory in every instance, the tumors gradually drying up and falling off with very little if any scar.

Case 7.—A little babe of nine months with a nævus, or port-wine mark (evidently a ruptured capillary or capillary aneurism) the size of a three-cent silver piece on the left cheek. The needle was thrust through this superficially, in three different places, and the circuit closed each time by pressing the positive sponge electrode on the opposite cheek. The operation was successful only in part, as there are now remaining two spots the size of pin heads.

My experience with electrolysis in this line convinces me that satisfactory work can be done in the great majority of cases. It is rather tedious work and very trying to the eyes, and while many unsightly growths may be removed it is not, as a rule, a profitable work financially for the physician.

Discussion.—In the discussion which followed the reading of this paper Dr. G. A. Hall reported one very marked case

that had fallen under his notice in which the steel needle used in this way had produced a marked discoloration of the integument resembling the gunpowder-mark. He should prefer the platinum needle so as to avoid the possibility of this mishap.

Dr. Holmes had gotten the idea from the well known authority, Dr. Fox, who especially disclaimed any such result from the steel needle, and his own patients had certainly escaped such a sequel.

Zyzigium jambolatum in diabetes.—By W. M. W. Davison, M. D.—Having lost my record of analysis of urine made, I can give only a general outline of treatment with results. The examinations of urine in each of three cases was made every week. The quantity of medicine used was the same per day in each case, viz.: fifteen drops of the mother tincture in the morning and at noon, and ten at night. In all forty drops daily were taken. The quantity of sugar per ounce differed in each individual case. In the first it was nearly twenty-two grains; in the second, twenty-five, and in the third, eighteen. After using the remedy for a week there was a marked diminution in the quantity of sugar present. At the end of the second week there was also marked decrease, but not a uniform lessening in each case. Again, one case would seemingly remain stationary for a period of two weeks, but by the persistent use of the drug the desired result would finally follow. Two of these cases recovered entirely at the expiration of two months, and for nearly a year now have maintained good health. One died a few weeks ago from facial erysipelas, so I am informed, but up to the time of death there was no recurrence of the old affection. In this case the diabetes was present for a period of two years previous to my treatment of the case. One of the others suffered for three years, while the third case, which failed to continue the remedy, at the end of six weeks told me he could not remember the time when he did not pass unusual quantities of urine. I meet him occasionally and he informs me that while the remedy benefited him at first it did him no lasting good, and

so he has gone back to his old remedy, *Spiritus Fermenti* ℥j, twice daily.

The ages of these respective parties vary between forty and fifty-five years. One was a woman at the menopause; two were men; all were of the lymphatic temperament and were excessive eaters. All of them suffered from excessive thirst, great dryness of the skin and profuse perspiration in summer following the least exertion. The woman, a year previous to treatment, suffered from successive crops of vulvar pustules with an occasional small abscess; sometimes a group of pustules would coalesce, making a severe sore which itched very much, almost driving her wild at times. One of the others suffered from carbuncles a year previous to the discovery of his diabetic condition. The family histories showed no trace of any hereditary disease.

Menorrhagia from chronic renal disease.—In remarking upon an obstinate case of hemorrhage at the month, Prof. Ludlam said, that of the various complications of this affection chronic lesions of the kidney were most apt to be overlooked. Physicians do not fail to remember that excessive menstruation is often chargeable to malaria, to indigestion, to improper food, drinks or exercise, and to various other indirect causes, but they do not always recollect that the urinary function may be seriously at fault, and that the proper therapeuties of the case may turn upon this point.

There is a clinical significance in the fact that the kidneys and the internal generative organs of the female are all derived from the Wolffian bodies. We cannot suppose that the intimate relations of fœtal life are a matter of accident, or that their significance does not also and in somewise extend to the adult. I have seen a case in which the uterus had been curetted, and both the ovaries and tubes had been removed, after the patient had been under medical treatment by all sorts of doctors for years, and without benefit, but still the flow continued. Whether a third or supernumerary ovary had been left behind, as sometimes happens after Battey's and Tait's operation for the arrest of hemorrhage in the case of fibroids, or if a shred of ovarian tissue had remained to stimulate the flow, could not be known. But it turned out that the woman had chronic nephritis, for which she had never been treated, and which accounted for the failure to relieve her by surgical means.

Hospital Notes.

THE CLINIC ON THE DISEASES OF WOMEN.

SERVICE OF PROF. R. LUDLAM.

Spasms during pregnancy.—*Case* 20025.—Mrs.——, aged twenty, and married. Her first child was born five months ago and it lived to be three months old. When about two months pregnant she began to have spasms, the first one being, apparantly, the result of a fright. She continued to have them as often as two or three times a day, until her child was born at term. She had no convulsions during labor and has had none since. She nursed the babe but little. It seemed very healthy but died suddenly, having first had three spasms. Her getting up was very good, but she complains now of feeling very weak and nervous, and has a poor appetite. The menses have been regular since the birth of the child. At present she suffers from a swollen face caused by a decayed and ulcerated tooth. *Mercurius sol.* 3.

The state of convulsibility is sometimes very marked during pregnancy. Women who are in this condition are the easy victims of spasms and convulsions for, under the circumstances, causes of nervous symptoms of this sort, which would ordinarily be of no effect, are sufficient to precipitate the paroxysm. And if one fit has been induced, another, and perhaps many of them, will almost certainly follow. It is impossible to say what kind of spasms our patient had during her pregnancy, but we may reasonably infer that if they had had their origin in any serious lesion, functional or organic, they could not have been so frequent nor so long continued without a resulting miscarriage, and more serious consequences to her own health. If they had been due to renal mischief they might indeed have ceased with her delivery, and with the return of a free flow of urine. But in that case her constitutional symptoms would have been more serious, and her labor attended by convulsions.

I know of no more ticklish question than to decide upon

the clinical significance of spasms which are not choreic during gestation, especially if they occur and recur after the second month. From that period until term the risk of serious trouble increases, and cases which at first may have been slight are very apt to develop into genuine eclampsia. They may sometimes escape any serious mischief, and finally cease by limitation, as in this instance, but it is not always so. Such cases will bear watching, and even, when they result from fright and other mental causes, should suggest a guarded prognosis.

Left ovaritis with salpingitis (?)—*Case* 20026.—Mrs.—, twenty-one years. Her first child was born twenty months ago, but it did not live long. She complains of pain in the left ovarian region, which is aggravated by walking; of tenderness and increased size of the left breast; of a bloating of the abdomen, which is especially noticeable toward night, and of painful menstruation. The flow has diminished in the last three months, and is not of a natural color. She has much pain in the back of the head, frequent nose-bleed, and occasional trembling spells. She can lie more comfortably on the left side. *Lilium*, 3.

The local pain in this case; the tumefaction and the tenderness of the left breast; the bloating of the abdomen upon exercise, and in the latter part of the day, and the dysmenorrhœa, with a decrease of the menstrual flow in so young a subject, are striking symptoms of a unilateral ovaritis. And you have certainly thought of that lesion, as these symptoms have been elicited. But this woman became a mother twenty months ago, and for that reason is much less likely to have simple ovaritis with dysmenorrhœa than if she were a maiden.

What are the peculiarities of ovaritis when it dates from the lying-in? A woman whose baby is but a few days old may have what is styled "ovarian peritonitis," or a circumscribed inflammation in the immediate vicinity of the affected ovary, but, excepting this acute form, puerperal and post puerperal ovaritis are of a secondary origin, and depend upon the extension of inflammation from the uterine cavity through the oviduct to the ovary itself. Hence the frequency of sal-

pingitis with ovaritis in those who have borne children at no very remote period. When this complication does not exist in this class of patients you may look for evidence of an ovarian abscess along with the symptoms of ovaritis.

The most discouraging obstacle to a correct and satisfactory diagnosis in cases of this kind is our forced ignorance of the puerperal history of the patient. This woman can tell us nothing of what she experienced during her lying-in. The doctor is not here to testify, and probably could not enlighten us if he were; and the nurse is *non est*, for she had none. In all human probability there was an endometritis, whether septic or not we can not say, which extended to the lining membrane of the left Fallopian tube, and thence to the corresponding ovary. The resulting mischief has been brewing ever since, with relapses at each menstrual return.

This is the type of a class of cases which are avoidable. They should be very rare, but they are not so. The custom of dismissing a woman as soon as her baby is born and named, and of turning her over to the tender mercies of a catch-nurse who is as ignorant of the contingencies of childbed as a hen is of Hebrew, is indefensible. If those who practice obstetrics were thoroughly familiar with the history and preventive treatment of the puerperal diseases, and careful to perform their whole duty in every case, the gynecologist would not only have less to do, but he would not so often be left in the dark as he is at present.

Uterine fibromata.—*Case* 20031.—Mrs. ——, colored, a widow, aged thirty-seven, has had no children. She has had a tumor for eight or nine years, but has never been ill with it until this spring. In February of this year she began treatment in Ohio, where they promised to cure her by poulticing the abdomen and giving her homœopathic remedies. About a month ago, while sitting over a pail of hot water for the relief of hemorrhoids, she had a hemorrhage from the uterus, from which she lost nearly a quart of blood. This was followed by the discharge of lumps and bits of flesh from the vagina. On the first of the present month a flow of water began, and lasted day and night for six days. If she rose to her feet she would have clots pass.

Physical examination discloses a uniform rotundity of the abdomen. It is not hard; has a tympanitic resonance; there is no area of dullness. The tumor began on the right and has grown toward the left side. Vaginal examination finds uterus retracted; the os is toward the coccyx, and the fundas turned toward the bladder. The vaginal cervix is movable, but the uterus is not. There is a hard growth low down in the right iliac region. The bowels never move without medicine. The sound strikes a body just above the internal os, and will not pass around it. *Trillium* 3.

There are several points of interest in this case. Observe that you see nothing particular upon inspection, and when I percuss the abdomen it is resonant. Palpation, however, detects an abnormal growth, which the patient says began in the right iliac region, like an ovarian tumor, and has developed toward the opposite side. This tumor has already been growing to her certain knowledge for about nine years, and still it is not so large as some that I have shown you, which have developed in a few months. This slowness of growth is peculiar to uterine fibroids, and it is almost pathognomonic when the presence of the tumor is accompanied by menorrhagia.

You should not forget that certain of these fibromata are accompanied by a free discharge of water, hydrorrhœa, which may cause them to be mistaken for uterine cancer. But in order that such a profuse and continuous flow of water as this patient has had should take place two conditions are requisite: (1) the tumor must be within the uterus, and (2) it must be of the soft or sarcomatous variety of fibroid.

Considering the predisposition of women of the colored race to this form of morbid growth, and the fact that so many years had elapsed since it first came, the absurdity of attempting to cure the case by any kind of poultice or of internal remedies is apparent. Here are undoubted signs of external, interstitial and internal fibroids, to the number, large and small, of a dozen or more perhaps, and it would be very wrong to expect or to promise to dispose of them by any such means. The only radical cure for such a case is by the extirpation of the womb. But hysterectomy is a very serious operation and should not be resorted to without the most careful consideration. If the hot weather were not upon us I would not hesitate to remove the womb in this case after the manner of Richelot and Péan, and without the use of any ligatures. As it is she will wait until the autumn.

Miscellaneous Items.

Prof. Bailey sailed for Europe in the steamship "Umbria," June 11, to be absent two months.——Prof. Crawford is in California.——Prof. Leavitt has changed his office to 48 Thirty-ninth Street.——Mrs. Dr. Canfield has a down-town office at 163 State Street.——Mrs. Dr. Parkhurst has gone abroad.——Dr. Lucy Waite has returned to Chicago, after three years hospital study in Vienna, Berlin and Paris.——Dr. G. H. Wright has opened a home for invalids at Carroll Springs, Forest Glen, Md.——Dr. A. Claypool's recent address as president of the Ohio Homœopathic Society, is an exceedingly practical production.——The double meeting of the Western Academy and of the Nebraska State Society, at Omaha, recently, was a marked success.——Dr. Crawford, of Cincinnati, was elected president of the Academy for the next year.——The unfortunate muddle concerning the Homœopathic College in San Francisco is not settled.——Gov. Adams has appointed Drs. J. M. Walker and J. J. Crook, of Denver, Col., members of the State Board of Medical Examiners for six years.——Dr. H. K. Macomber, of Pasadena, Cal., is on a visiting trip to Chicago, New York, Boston and the Institute at Saratoga.——Dr. W. H. Parson's paper on Thymic Asthma came too late for insertion in this issue.——Look out for some startling news from the "Old Hahnemann." The Announcement and Catalogue will appear shortly.——Dr. Louise Fiske Bryson is at 15 West Thirty-fourth Street, New York.——Dr. W. T. Branstrup has been appointed a member of the city board of health of Topeka, Kas., and is now secretary of the same.——Dr T. M. Gillespie has donated $20 to the hospital fund.——A terrible runaway accident, by which she was thrown from her carriage, resulted in the death of Mrs. Fidelia Gray Macomber May 29. She graduated in the Hahnemann in 1879, and has since resided and been in active and very successful practice in Atlantic, Iowa.——Dr. M. A. Bowerman has changed her office and residence to 1310 Oakwood Boulevard.——The late Prof. Farrington's lectures will soon be issued under the practical and sensible title of "A Clinical Materia Medica."——It is to be hoped that the "sectional plan" to be inaugurated at the meeting of the Institute in Saratoga will be set in motion without any sectional feeling on the part of the members.——The amended bill giving the Illinois State Board of Health increased power and privileges has passed the Legislature and become a law.